Taking Health Integration Full Scale:

Fully Engaging Staff and Consumers in a Culture of Wellness

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Our Journey to Integrated Health

- Understanding of the Health Care Issues/Problem for persons with co-occurring Serious Mental Illness
- The role of the On-site Integrated Health Care Clinic, Lessons Learned and Successes
- Next steps in the development of Integrated Health Model

HEALTHWEST
Fiscal year 2014

We served:

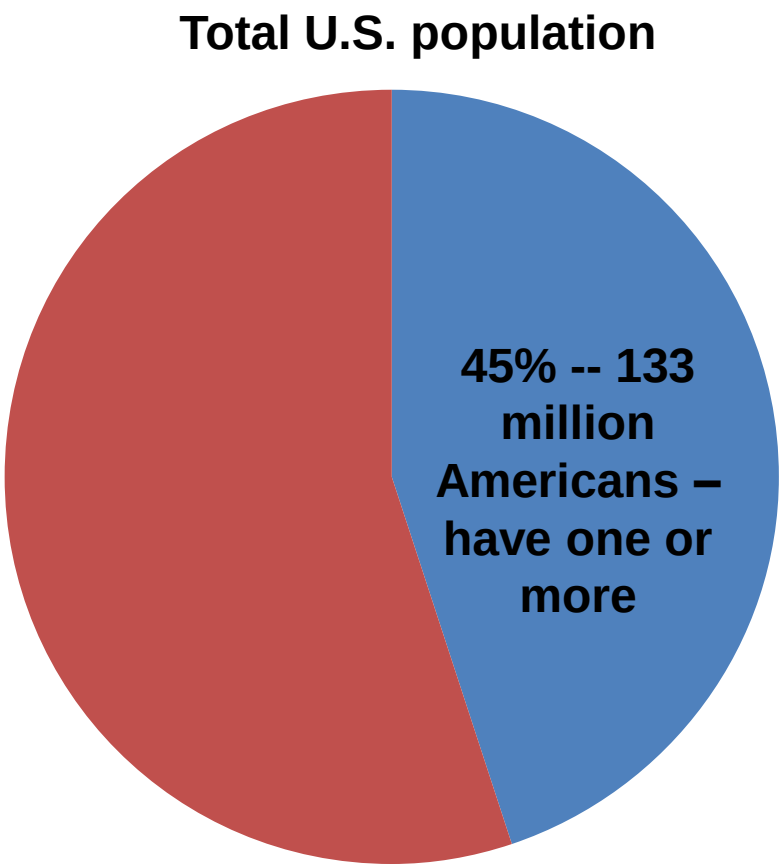
- 2,026 Adults with SMI
- 761 Adults with developmental disabilities
- 690 Children with serious emotional disturbance
- 266 Children with developmental disabilities
- 197 are un-insured
- 185 have **no** primary care physician

Chronic Illness: Unsolved Burden in US Healthcare

- Chronic illness accounts for **75%** of the approximately $2 trillion Americans spend each year on health care cost
- Our medical system is primarily set up to treat acute illness.

Partnership to Fight Chronic Disease- The Almanac of Chronic Disease 2008 Edition

Nearly half of Americans have one or more chronic diseases



Wu S, Green A. Projection of Chronic Illness Prevalence and Cost Inflation. RAND Corporation, October 2000.

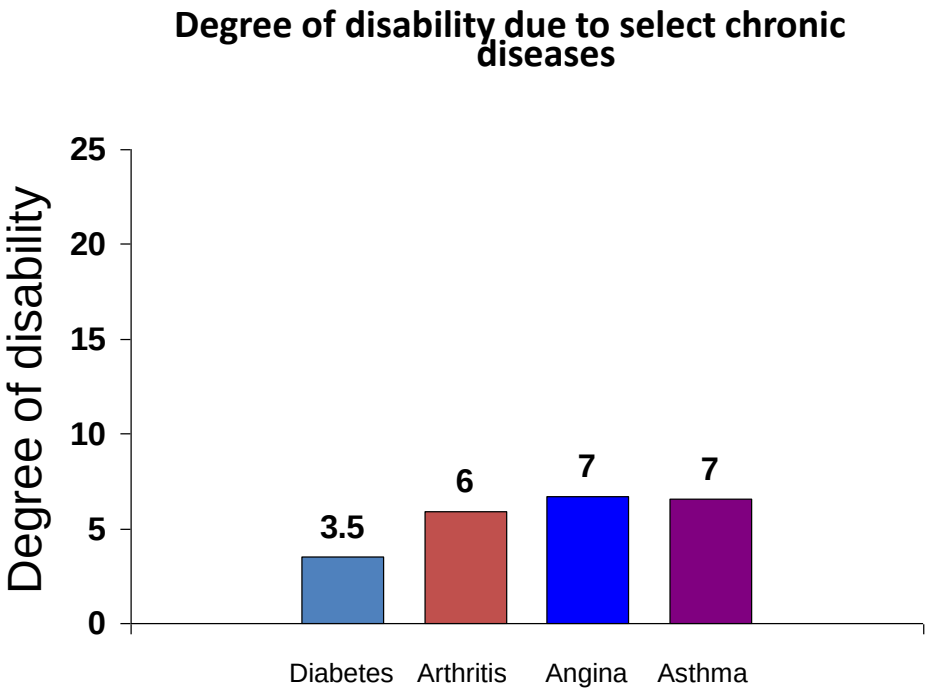
Depression with Chronic Illnesses

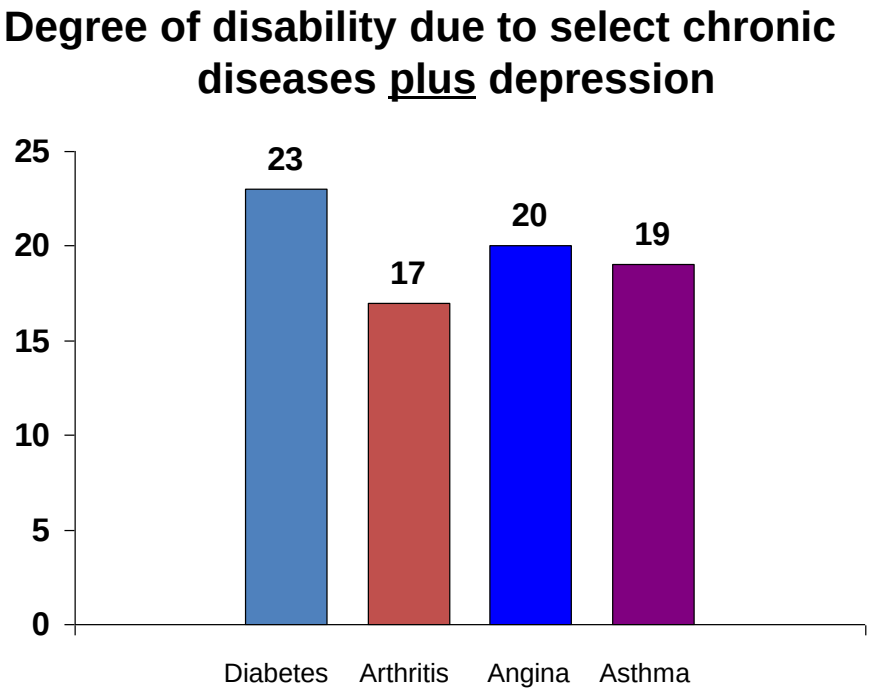
Increased rates of depression in patients with:

- Congestive Heart Failure
- Diabetes
- COPD
- Patients with chronic illness and depression: 2-5x the healthcare cost of patients with chronic illness alone
- Depression is the common factor in patients disabled (compared with patients equally sick but not disabled) by hypertension, asthma, arthritis, ulcers.

Bachman, J. http://www.wpic.pitt.edu/dppc/downloads/Depression_in_Disease_Management_Practices_for_Chronic_Conditions_FINAL.doc

Mental health conditions, such as depression, dramatically increase disability* when paired with other chronic health conditions





*Disability is the measure of difficulty completing important and ordinary life tasks and roles.

WHO World Health Survey, Moussavi, et al, (2007) Lancet

Persons with SMI and chronic illness

- People with SMI have more chronic illnesses than matched populations of Medicaid recipients.
- These lead to largely **preventable** poor outcomes.
- List includes: diabetes, metabolic syndrome, lung and liver diseases, high blood pressure, cardiovascular diseases, infectious diseases and dental disorders.
- Individuals with severe disabilities tend to have shorter life expectancy due to increased medical complications.

County Health Rankings

Muskegon ranks last in Health Behaviors (82nd) in Michigan ; smoking, obesity, food environment index, physical inactivity, access to exercise, excessive drinking, alcohol related deaths, STI, teen births.

County Health Rankings & Roadmaps, Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, updated 2015

“Muskegon County, Michigan is one of the most obese counties in the state of Michigan, which happens to be one of the most obese states in the nation”

Muskegon County’s Public Health *Muskegon County Health Profile 2012*

Most Prevalent Chronic Conditions for Persons with SMI

- Asthma
- Diabetes
- Cardiovascular Disease
- Irritable Bowel Syndrome
- Obesity
- Unhealthy Substance Use
- Depression

Most Frequently Occurring Health Conditions for People Served at HealthWest

- Obesity
- Diabetes
- Hypertension
- Asthma
- Hyperlipidemia
- At least one-third smoke cigarettes

Why Are Persons with SMI Not Accessing Health Care

- Lack of information about services
- Shortage of appropriately trained health providers
- Transportation and access problems
- Lack of adequate health insurance coverage
- Cultural and language barriers
- Limited patient education materials
- Lack of health care standards/guidelines
- Stigma

Integrated Health Clinic

"Improve the quality of life for persons with serious mental illness through holistic, integrated, coordinated health care"

Collaborative Setting

"Treatment compliance for medical problems is increased when delivered in a collaborative setting"

LaBrie et al., 2007

Integrated Health Clinic

- Currently in operation 4 days per week
- Part-time Physician's Assistant (from FQHC)
- Part-time Physician (from FQHC)
- Psychiatrist (CMH)
- Psychiatric Physician's Assitant (CMH)
- Three Registered Nurses (CMH)
- Full-time Clerical Support (CMH)
- Integrated Health Care Coordinator (CMH RN)
- Director Medical Services (CMH RN-BC)
- Supervision provided by FQHC Medical Director
- On site laboratory
- On site pharmacy

IHC Patient/Visit Data

1562 Visits * 343 Patients

Chronic Disease	Number of patients
Diabetes	75
Hypertension	120
Hyperlipidemia	77
Asthma & COPD	78
Obesity	175

Real Life Examples

- Craig-54 y/o male
- Dx: Schizophrenia, HTN, Tobacco use, Hyperlipidemia
- Poor historian
- Presents with right sided chest pain, only after eating, minimizes symptoms—Non-typical cardiac picture
- Prevalent thought disorder at baseline
- PCP concerned—ordered stress test—coronary artery bypass surgery completed 2 days later

Real Life Examples

- Jerry- 64 y/o male
- Dx: Schizoaffective disorder, COPD, HTN, Tobacco Use, Marijuana Use
- Presents with weakness in legs and arms
- Both AFC provider and HealthWest worker felt he was “lazy”, “behavioral”, “drug seeking”
- PCP ordered MRI, insurance refused payment until PCP argued “the case”, delaying testing
- MRI results: Severe stenosis with cord displacement- Radiology called for immediate transfer to hospital by ambulance
- ER doctor & neurosurgeon---PCP prevented paralysis/death by seeing beyond the behavioral health dx

National Diabetes Fact Sheet

According to the 2011 National Diabetes Fact Sheet… 25.8 million children and adults in the United States --- 8.3% of the population --- have diabetes.

According to the 2014 National Diabetes Fact Sheet… 29.1 million children and adults in the United States --- 9.3% of the population --- have diabetes.

Higher Rates of Diabetes for Persons with SMI

- 15% for those with Major Depression
- 16-25 % for those with Schizophrenia
- 25 % for those with Bi-polar Disorder
- 50 % for those with Schizoaffective Disorder

Bazelon Center for Mental Health Low (2004)

Diabetes

- One provider at the IHC: 25% of her patients have diabetes. All people served at the IHC received CMH services and have Chronic Disease concerns.

- Fifteen providers at HCCC (FQHC): The percentage of patients with diabetes per provider at HCCC range from 5%-17%.

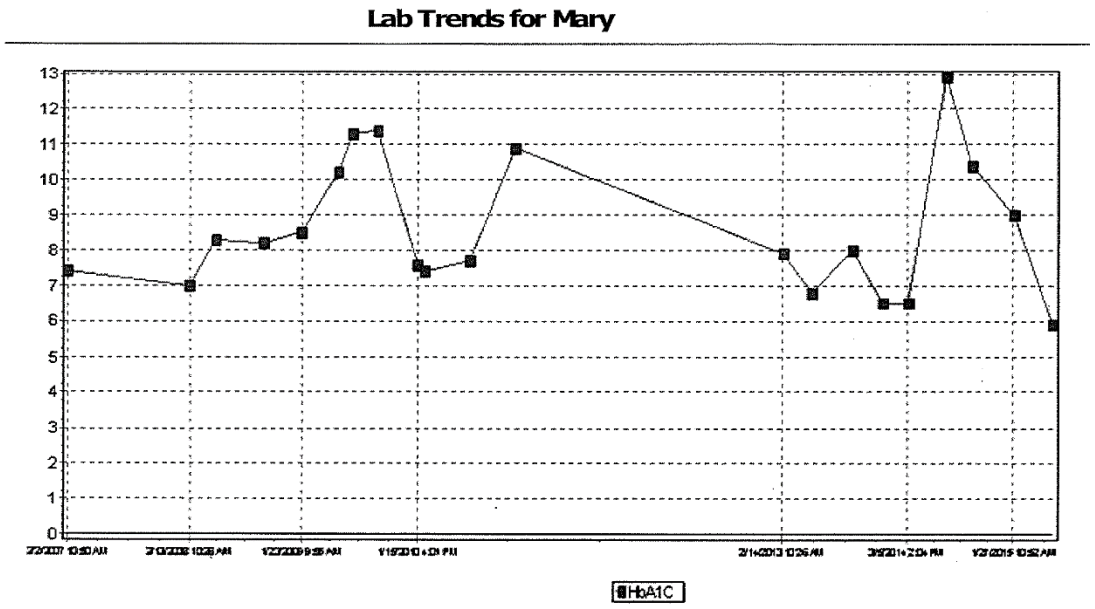
Diabetes Summary Report for Integrated Health Center

Diabetic Summary 2015 - Schram

Month	Number of Patients	Blood Pressure < 140/90	LDL < 100	Avg HbA1C	HbA1C less than or equal to 8.0	HbA1C less than or equal to 9.0	Pts with at least 1 HbA1C in the last year	ACE Inhibitors or ARB Medication	Microalbumin Annually	Dilated Eye Exam Annually	DM Dental Exam Annually	Pts on Statin
January	57	68.4%	75.4%	7.2	70.2%	84.2%	98.2%	28.1%	80.7%	49.1%	15.8%	71.9%
February	56	66.1%	73.2%	7.3	73.2%	83.9%	100.0%	87.5%	78.6%	48.2%	10.7%	82.1%
March	54	64.8%	72.2%	7.3	74.1%	81.5%	100.0%	87.0%	81.5%	44.4%	9.3%	81.5%
April	56	73.2%	67.9%	7.4	73.2%	80.4%	100.0%	89.3%	82.1%	39.3%	5.4%	85.7%
May	56	75.0%	66.1%	7.2	78.6%	83.9%	100.0%	87.5%	85.7%	35.7%	3.6%	85.7%
June	56	75.0%	67.9%	7.2	80.4%	83.9%	100.0%	89.3%	85.7%	37.5%	5.4%	87.5%
*National Diabetic Collaborative Goals		>40%	>70%	<8%		>75%	>90%	>75%	>50%	>70%	>70%	

- Mary is a 50 y/o female
- Dx include Schizoaffective Disorder, HTN, Chronic Pain, Asthma, Diabetes Type II, Insulin Dependent, Chronic Kidney Disease, Stage 3
- 2/13 - Joined IHC, living in AFC, A1C: 7.9
- 7/14 - Moved to independent living , diabetes became poorly controlled with A1C: 12.9, Blood sugar 1091 --- hospitalized
- Weekly IHC visits, HealthWest SC and Nurse Care Manager actively involved, Guardianship changed, placed in Crisis Residential then returned to AFC home
- 5/27/15 A1C: 5.9
- Long acting Insulin 100 units daily to now 10 units daily

Lab Trends for Mary



Reduction of ER Visits

- “Maria” is a 29-year old female who had her initial visit to the IHC on 5/16/2012
- She has 9 ER visits from 3/1/2011 to 3/31/2012
- She has had 4 ER visits from 4/1/2012 to 4/30/2013
- She has had 7 ER visits from 5/1/2013 to 5/31/14
- She has had 1 ER visits from 6/1/2014 to 6/30/15
- The number of ER visits was reduced by 90% after coming to the IHC with increased multidisciplinary team involvement.

What Makes it Work?

- Team work
- Using Evidence-Based Practices
- Providing additional training to staff
- Convenience of Integrated Care under one roof
- Collaboration with community partners
- Support of administration
- Rapid response to behavioral health/medical concerns
- Having the right team members (IT, Finance, Clerical, etc.)
- Flexibility – “Thinking outside the box”
- Activity of advocacy

What Makes it Work ?

- There is no health-disparity for the diverse population served in the Integrated Health Clinic.
- 30 minute appointments instead of standard 15 minute appointments. (Trauma Informed Care)
- Health promotion programs
- Support provided to individuals, families, and other caregivers in self-care and wellness.

Laboratory Services

- On-site Laboratory services
- Point-of-care testing (A1C, Hgb, Glucose, UA, PT, Strep Screen, Pregnancy Test)
- CLIA Certified (Certificate of waiver from the Centers of Medicare and Medicaid for Laboratory Improvement Amendments)
- Additional testing is done via obtaining specimens on-site by medical staff and send them for off-site testing
- Results for off-site testing are available for most tests by 7:00 a.m. the following business day.

Benefits of an On-site Pharmacy

- We have established “working relationships” with local pharmacies.
- Adds another link to providing care in an integrated manner.
- Consumer leaves appointment with medications in hand, increasing adherence.
- Full service pharmacy: all meds and all scripts can be filled.
- Pharmacist is part of the “care team”. (Coordination of Care)
- Less stress for consumers and less workload for staff.
- Adds convenience to assist with adherence
- Medication issues/concerns immediately reported to team members (insurance issues, meds not picked up, etc)
- Medication Packaging On site

Future Plans

- Increase hours of operation from 32 to 40 hours per week
- Dental Clinic
- Modify space in current clinic to accommodate all primary and behavioral health services in one clinic
- Further develop and implement protocols for care coordination (especially those with 2 or more chronic diseases)
- Increase Cultural Competencies
- Addressing Secondary Trauma

The Big Picture

- We learned that Integrated Health is much more than Integrating Primary Care and Behavioral Health.
- It includes helping our staff understand their own health care needs before they can assist to address the health care needs of consumers.
- It is about promoting a healthy community.
- Ultimately it is about the collaboration of partnering agencies addressing Integrated Health Care in the community at large.

Lessons Learned & Ongoing Strategies

In spite of the many achievements of the integrated health clinic, we continue to struggle with successful integration of physical and mental health:

- Muskegon ranks last (82nd out of 82 counties) in Michigan when compared to other counties in the state in healthy behaviors
- Staff are uncomfortable addressing physical health issues with clients; often defer to nursing staff
- Staff health habits are poor and many struggle with chronic health issues
- Staff lack knowledge to reinforce healthy behaviors
- There is a lack of time, resources and opportunities for staff and individuals receiving services to focus on physical health
- Stigma

In response, we've developed a new program…

Let's Get…

Better Together

So much more than the average wellness program

Program Overview

- "Better Together" is funded by a Block Grant from the Michigan Department of Community Health

- Partners include:
  - Community Mental Health Services of Muskegon , Allegan and Ottawa Counties
  - Access Health
  - Hackley Community Care
  - MSU Extension
  - Muskegon & Holland Farmer's Market
  - Local businesses

- ***Guiding Philosophy***: In order to get healthier, we all need knowledge, tools, and support. We believe our staff and clients will have positive outcomes if we *work together*.

- Staff get trained to be health coaches and then are paired with an individual receiving services. Pairs *work together* and support each other to reach their health goals.

Program Requirements

Create a culture of health and wellness through the Lakeshore Regional Partners by implementing “Better Together” wellness programs for staff and individuals receiving services within a model of practice that includes indicators for medical and healthy behavior outcomes.

Summer Activities

Drop in to any activity to see if it fits in your wellness plan.

Outdoor Training (Exercise stations will include: resistance bands, muscle building, walking, stretching and cardio (good for your heart) exercises)	Mondays at 4:00-5:00 PM Heritage Landing Stage
Tai Chi (Mindfulness, Moving Meditation, Stress Reduction)	Mondays at 5:00 PM Boardroom B
YOGA (Stress Reduction and Mindful Movement)	Tuesdays at noon Boardroom B
YMCA Veggie Van (Fresh Produce to Purchase)	Tuesdays 12:45-1:45 PM Main lobby or out front
Health Coaching (Talk to a Health Coach from Access Health for one on one advice)	Wednesdays 9:00-10:00 AM Interview Room A12
Walking Club (Walk with Friends, different types of walks each week)	Wednesdays 4:00-5:00 PM Meet in the Main Lobby
Access Health Classes (Weekly Health and Wellness Classes)	See list

Access Health Classes

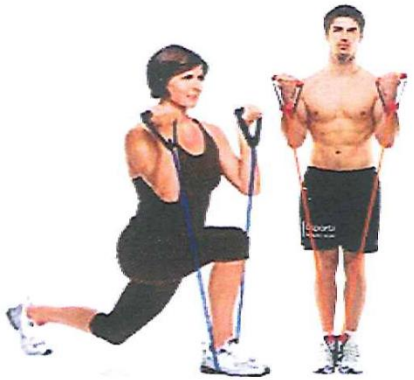
Tuesday, July 14 1:00pm	Superfoods, Board Room C
Thursday, July 23 4:00pm	Sweet Consciousness, Board Room B
Thursday, July 30 12 noon	Resistance Bands Board Room B
Tuesday, August 4 4:00pm	Alternative Food Board Room C
Tuesday, August 11 4:00pm	Lifestyles Changes, Board Room B
Thursday, August 20 9:00am	Stretch for Health, Board Room B
Tuesday, August 25 4pm	No Equipment Needed, Board Room B

DATE	CLASS & TIME	TEACHER
Thursday, July 9	*What's On Your Plate: 12 Noon* Board Room A Learn how to navigate food choices	Candy
Tuesday, July 14	*Superfoods, 1:00pm* Board Room C What is a superfood and should we be eating more?	Josh
Thursday, July 23	*Sweet Consciousness, 4:00pm* Board Room B How does what we eat change our blood sugar? Learn how sugar affects the Body and mood.	Miguelle
Thursday, July 30	*Resistance Bands: 12 noon* Board Room B Learn to use this compact, affordable, & mobile tool as part of your routine.	Jean
Tuesday, August 4	*Alternative Food Styles, 4:00pm* Board Room C Overview some of the current nutritional approaches & fad diets.	Mike
Tuesday, August 11	*Lifestyles Changes, 4:00pm* Board Room B Identify and implement positive changes for your health.	Jeff H.
Thursday, August 20	*Stretch for Health, 9:00am* Board Room B Incorporate stretching in your daily routine to avoid injury.	Josh
Tuesday, August 25	*No Equipment Needed, 4:00pm* Board Room B Learn how to structure a workout without special equipment, using just your body and what you have at home.	Mike
Thursday, September 3	*Eat For Your Health, 1:00 pm* Board Room C Get some new ideas about making healthy nutrition choices.	Jean

YMCA VEGGIE VAN

Access Health Presents

Resistance Bands



Learn how to use resistance bands to improve your strength, endurance and flexibility. This one band can do it all!!

When: Thursday, July 30th at 12:00 noon

Where: HealthWest Board Room B

Please wear comfortable clothes and shoes that will allow you to participate in the exercises.

Access Health Presents

"LIFESTYLE CHANGES"

TUESDAY, AUGUST 11TH

4:00PM HealthWest Board Room B

Find new ways to achieve your health goals, whether it's exercising more or improving our diet.

The important thing is figuring out *why* we want these things.

Presented By Health Coach Jeff Hardy

Outdoor Training with Jean Seward, Health Coach

access:health™

Enjoy the movement and activity. Exercise stations will include: resistance bands, muscle building, walking, stretching and cardio (good for your heart) exercises.

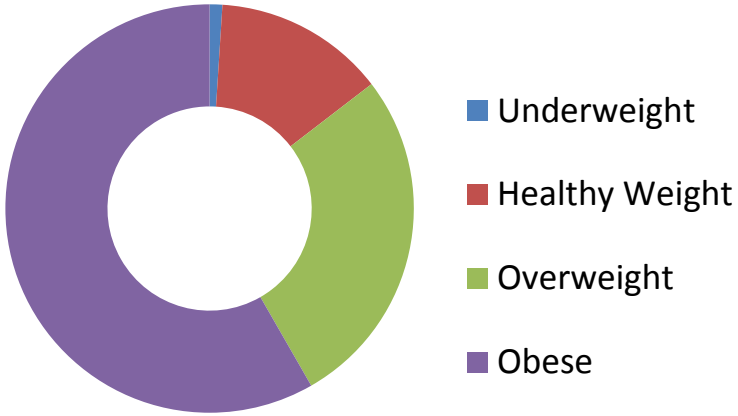
All levels of ability welcome.


Pedal
While You
Wait

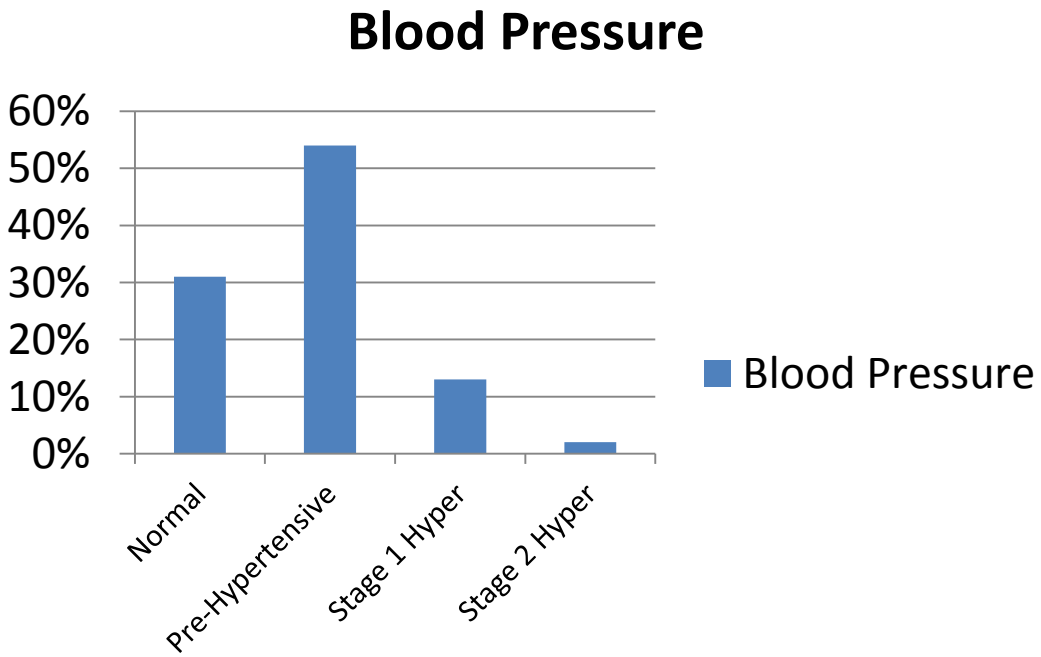
Baseline Data

- 300 participants from Muskegon, Allegan & Ottawa CMH
- Measures of success:
  - 50% of participants will have a 5% improvement in one or more of the following health measures: BMI, weight, Blood Pressure, HgBA1C, Lipids
  - 90% of all consumer participants will have a self-management goal to improve overall health reflected in their Person Centered Plan

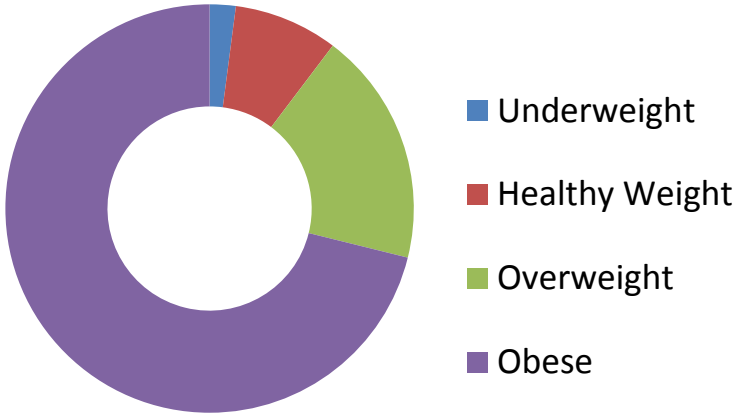
Baseline Data: Staff



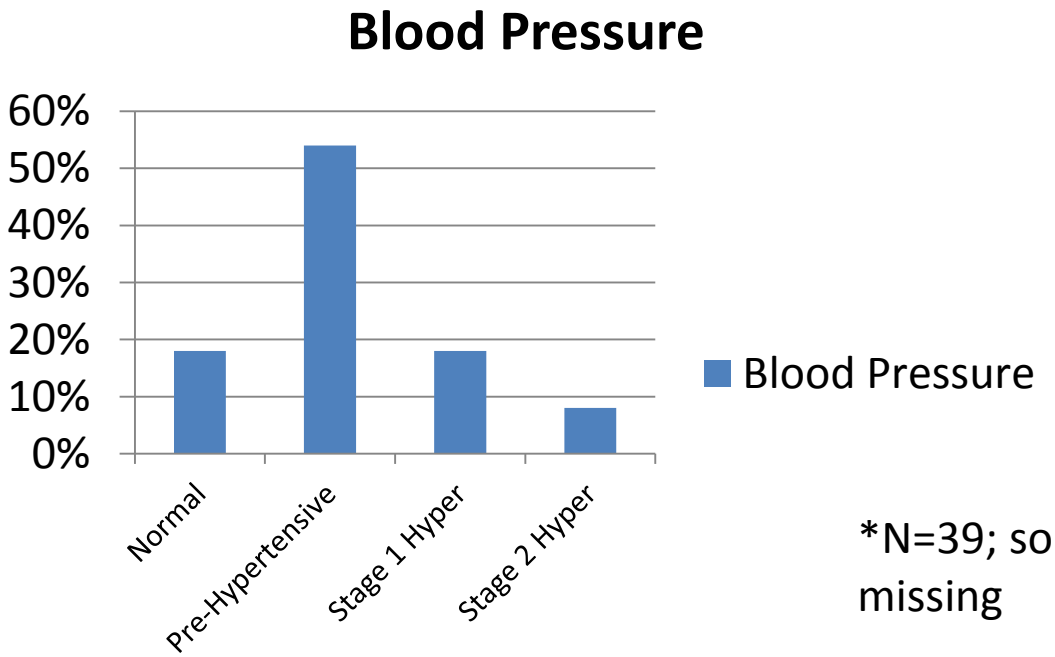
- Average BMI of staff: **31.4** (obese)
- 85% of staff are overweight or obese
- Average Weight: 189.09 lbs
- Average waist circumference: 38.9 in.



Baseline Data: Consumers*

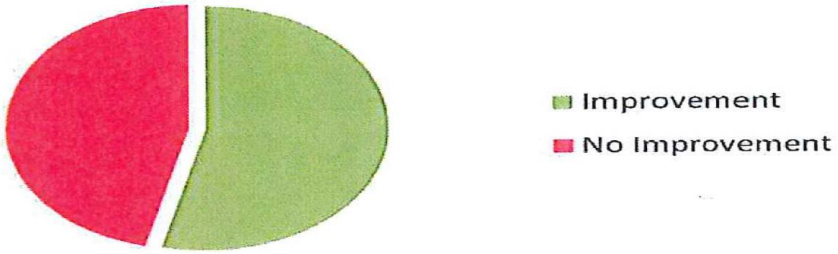


- Average BMI of staff: **34.6** (obese)
- 87% of consumers are overweight or obese
- Average Weight: 215.47 lbs



*N=39; some data missing

Improvement in Health Measures



Total LBS lost: 327.10

Those who lost weight lost an average of 9.91 lbs.

65/107 participants had start, midpoint, and end point data (61%)

41 out of 76 individuals had improvement in health measures (53%)

- 68% of participants report regular (weekly) contact with their partners (n=43, End Point Survey)
- 60% report their exercise habits have improved; 63% report improved eating habits; 47% report their stress levels have improved (n=43)
- 93% report they are making positive progress towards their health goal (n=43)
- Participants report using their gym memberships an average of 6 times per month (n=43)

Quick Health Fact!

Did you know…?

Literacy skills are a stronger predictor of an individual's health status than age, income, employment status, education level, or racial/ethnic group

Achievements to Date

- Remodeling of a wing of CMH to accommodate primary care
- Expansion from two to five exam rooms equipped to provide primary care
- Development of primary care assessment forms and data collection tools
- Memorandum of Understanding with Hackley Community Care (FQHC)
- Established billing processes
- Primary care services provided on-site to individuals

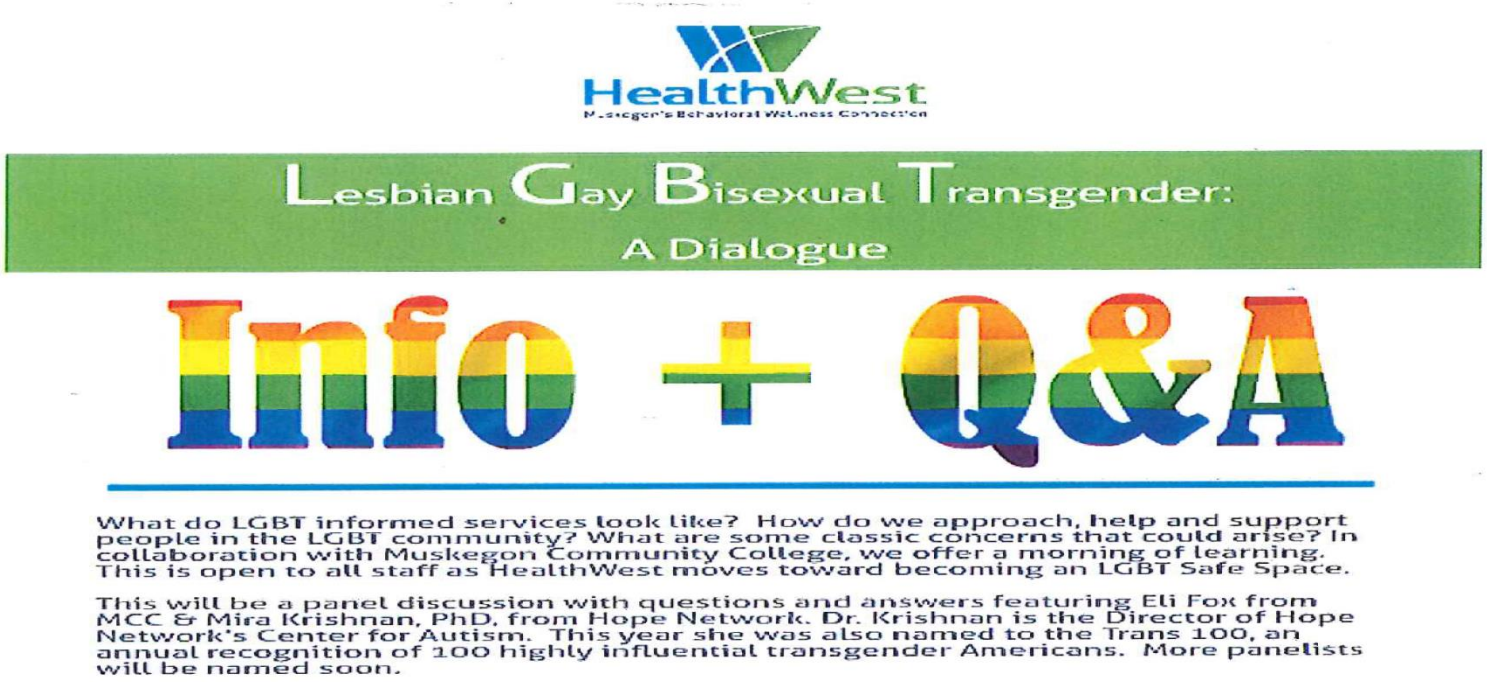
Achievements to Date

- Trained 17 CMH RNs and 5 FQHC RNs to Certified Nurse Care Managers (UMASS Model)
- Co-location of Psychiatric Services with the Primary Care Clinic
- Awarded the PBHCI grant to expand services
- Multidisciplinary teams are in place
- Staff and consumers are participating in wellness activities together

Lessons Learned and Ongoing Strategies

- PBHCI Weekly Case Consultations
- Individual Team Trainings Regarding Integrated Care/Culture of Wellness
- Team Communication with Primary Care Doctors and Psychiatrists
- Address Health Care Disparities (LGBT)

Persons ADRESSING STIGMA



Lessons Learned and Ongoing Strategies

- Primary Care Physicians lack of time to address multiple issues
- Need to increase Peer Support Involvement
- Addressing Stigma , continues to be a barrier
- Addressing Trauma, ACES study
- Share lessons and strategies with Community Health Care Partners (ER, Primary Care Practices)